The MARYLAND
HEALTH CARE COMMISSION

Benchmarks for Preauthorization of Health Care Services

Draft Regulations

For Informal Public Comment

The Maryland Health Care Commission (MHCC) was given the authority under House Bill 470, Preauthorization of Health Care Services - Benchmarks, signed into law on May 22, 2012, to adopt regulations that adjust certain benchmark timelines, require payers and providers to comply with the benchmarks, and establish penalties for non-compliance. The law also gives the MHCC the authority to establish regulation for the criteria and process through which a payer may be waived from attaining the benchmarks The MHCC is seeking informal public comment to this draft. Informal public comments will be accepted via email until the end of the day on Thursday, August 30, 2012 and should be submitted to Angela Plunkett at aplunkett@mhcc.state.md.us.

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Title 10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 25 MARYLAND HEALTH CARE COMMISSION

Chapter 17 Benchmarks for Preauthorization of Health Care Services

Authority: Health-General Article §§19-101 and 19-108.2

Annotated Code of Maryland

.01 Scope.

This chapter applies to a payor that:

A. Requires preauthorization for health care services; and

B. Is required to report to the Maryland Health Care Commission (Commission) on or before certain dates on its attainment and plans for attainment of certain preauthorization benchmarks.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Commission" means the Maryland Health Care Commission.

(2) "Executive Director" means the Executive Director of the Commission or the Executive Director's designee.

(3) "Health Care Service" has the meaning stated in §15-10A-01 of the Insurance Article.

(4) "Payor" means one of the following that requires preauthorization for a health care service:

(a) An insurer or nonprofit health service plan that provides hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State;

(b) A health maintenance organization that provides hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State; or

(c) A pharmacy benefits manager that is registered with the Maryland Insurance Commissioner.

(5) "Preauthorization" means the process of obtaining approval from a payor by meeting certain criteria before a certain health care service can be rendered by the health care provider.

.03 Benchmarks.

A. On or before October 1, 2012, each payor shall establish online access for a provider to the following:

(1) A list of each health care service that requires preauthorization by the payor; and

(2) Key criteria used by the payor for making a determination on a preauthorization request.

B. On or before March 1, 2013, or another date established by the Commission, in consultation with its multistakeholder workgroup and published in the Maryland Register, each payor shall establish an online process for:

(1) Accepting electronically a preauthorization request from a provider; and

(2) Assigning to a preauthorization request a unique electronic identification number that a provider may use to track the request during the preauthorization process, whether or not the request is tracked electronically, through a call center, or by fax.

C. On or before July 1, 2013, or another date established by the Commission, in consultation with its multistakeholder workgroup and published in the Maryland Register, each payor shall establish an online preauthorization system that meets the requirements of §19-108.2(e) of the Insurance Article to approve:

(1) In real time, electronic preauthorization requests for pharmaceutical services:

(a) For which no additional information is needed by the payor to process the preauthorization request; and

(b) That meet the payor's criteria for approval;

(2) Within one business day after receiving all pertinent information on requests not approved in real time, electronic preauthorization requests for pharmaceutical services that:

(a) Are not urgent; and

(b) Do not meet the standards for real-time approval under item (1) of this item;

(3) Within two business days after receiving all pertinent information, electronic preauthorization requests for health care services, except pharmaceutical services, that are not urgent.

D. A payor that becomes authorized to provide benefits or services within the State of Maryland after October 1, 2012 shall meet each benchmark in Regulation .03B of this chapter within three months of the payor's offering of services or benefits within the State.

.04 Reporting.

A. On or before March 1, 2013, a payor shall report to the Commission in a form and manner specified by the Commission on:

(1) The status of the payor's attainment of the benchmarks in Regulation .03A and B of this chapter; and

(2) An outline of the payor's plans for attaining the benchmark in Regulation .03C of this chapter.

B. On or before December 1, 2013, a payor shall report to the Commission in a form and manner specified by the Commission on the payor's attainment of the benchmarks in Regulation .03C.

.05 Waiver from Benchmark Requirement.

A. A payor may request that the Commission issue or renew a waiver from the requirement to meet a benchmark in Regulation .03B of this chapter by the demonstration of extenuating circumstances including:

(1) For an insurer or nonprofit health service plan, a premium volume that is less than one million dollars annually in the State;

(2) For a pharmacy benefit manager, _____;

(3) For a group model health maintenance organization, as defined in §19-713.6 of the Health-General Article, preauthorizations of health care services requested by providers not employed by the group model health maintenance organization; or

(4) Other circumstances determined by the Executive Director to be extenuating.

B. Submission of request for waiver or renewal of waiver.

(1) A request for a waiver or renewal of waiver shall be in writing and shall include:

(a) A description of each preauthorization benchmark for which a waiver is requested; and

(b) A detailed explanation of the extenuating circumstances necessitating the waiver.

(2) A request for a waiver shall be filed with the Commission in accordance with the following:

(a) For the benchmark in Regulation .03A of this chapter, no later than 30 days after the effective date of this chapter;

(b) For benchmarks in Regulation .03B and C of this chapter, no later than 60 days prior to the compliance date; or

(c) For renewal of a waiver, no later than 45 days prior to its expiration.

(3) For a payor that becomes authorized to provide benefits or services within the State of Maryland after October 1, 2012, within 30 days after the date the payor is authorized to provide benefits or services within the State.

C. Issuance of Waivers

(1) The Executive Director may issue a waiver from a preauthorization benchmark to a payor that demonstrates extenuating circumstances within this chapter.

(2) A waiver or renewal of a waiver shall be valid for one year, unless withdrawn by the Executive Director, after notice to the payor.

D. Review of Denial of Waiver.

(1) A payor that has been denied a waiver may seek Commission review of a denial by filing a written request for review with the Commission within 20 days of receipt of the Executive Director's denial of waiver.

(2) The full Commission may hear the request for review directly or, at the discretion of the Chair of the Commission, appoint a Commissioner to review the request, who will make a recommendation to the full Commission.

(3) The payor may address the Commission before the Commission determines whether or not to issue a waiver after a request for review of denial of waiver by the Executive Director.

E. A waiver or renewal of waiver from the requirements of this chapter may not be sold, assigned, leased, or transferred.

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